October DY5 Quantifiable Patient Impact (QPI) Reporting Companion Document

Table of Contents:

While some of the content below repeats information from the October DY5 Reporting Companion Document, this document provides important details regarding QPI reporting that are not included elsewhere. Please read both documents carefully to ensure that QPI reporting is completed correctly.

Reporting on QPI

The QPI Reporting Template is required when reporting achievement for designated QPI metrics (marked "Yes" in the QPI Metric cell) and for metric-level Semi-Annual Reporting (SAR) in October.

Semi-Annual Reporting (SAR)

Every October, as part of the metric-level progress update required for Semi-Annual Reporting (SAR), HHSC will require all projects with a designated QPI metric in the demonstration year (DY) to submit the number of individuals served/ encounters provided in the DY due to the DSRIP project via a QPI Reporting Template.

Providers who submit a QPI Reporting Template in April 2016 to report achievement of a DY4 carryforward or DY5 QPI metric will still need to submit the QPI Reporting Template updated with data from the full demonstration year in October 2016. **Providers need to update all DY5 data** (MLIU percentage actuals in Step 2, QPI Actual (Provider Calculation) in Step 3, encounter data in Step 6, and data details (dates and description) in Step 7). This data should be updated regardless of the DY5 reporting status (previously reported for achievement or not ready to report). DY3 data previously reported for achievement and approved will not need to be updated. This annual information will be important for external communications regarding the impact of the DSRIP program.

Metric Achievement

While providers are required to submit Semi-Annual Reporting (SAR) progress updates in the QPI template in October reporting, they may report achievement of metrics for payment in *either* April or October of the demonstration year (DY). Alternatively, in October, if the metric is not fully achieved by September 30, a provider may request to carry forward the metric to the subsequent demonstration year.

QPI metrics (like all Category 1 or 2 metrics and Category 3 milestones) should only be reported for achievement if the provider is confident that the metric was fully achieved during the allowable dates of service and can be clearly demonstrated.

Please note that, generally, **QPI should only be counted after certain DSRIP activities critical to the project have been implemented**. For example, if the goal of a project is to implement a medical home, QPI should only be counted after medical home designation is achieved. Similarly, if the goal of a project is to expand primary capacity to rural areas by opening a new clinic, QPI should only be counted once the rural clinic is open. Providers should be clear, in their QPI templates and/or progress updates, that these activities have been completed when reporting QPI.

Allowable Dates of Service

Only individuals served/ encounters provided during the demonstration year (DY), or during the DY and the subsequent DY if reporting as carryforward, may be counted as QPI. While QPI metrics may be achieved in a subsequent demonstration year as carryforward, they may not be achieved in an earlier demonstration year. For example, if a project includes a QPI metric in DY3 and serves more individuals or provides more encounters in DY3 than included in the DY3 goals, the additional individuals/encounters from DY3 cannot be counted toward DY4 QPI

goals. Early achievement of QPI metrics is not allowed in order to ensure that each project's impact on patients continues to grow throughout the waiver demonstration period.

The allowable dates of service for QPI metrics are as follows:

Metric DY	Not Reporting as Carryforward	Reporting as Carryforward
DY3	Oct. 1, 2013 – Sep. 30, 2014	Oct. 1, 2013 – Sep. 30, 2015
DY4	Oct. 1, 2014 – Sep. 30, 2015	Oct. 1, 2014 – Sep. 30, 2016
DY5	Oct. 1, 2015 – Sep. 30, 2016	Oct. 1, 2015 – Sep. 30, 2017

For October DY5 reporting, the services end date for QPI individuals/encounters is September 30, 2016 for both DY4 carryforward reporting and DY5 reporting. Individuals/encounters submitted with dates after September 30, 2016, cannot be counted as QPI for the October DY5 reporting period; if eligible for DY carryforward, they may be reported in DY6A reporting.

Please note that, if a QPI metric is carried forward for late achievement, the provider will need to demonstrate achievement of the carryforward metric before the subsequent year's QPI metric is approvable.

Multiple Metric Goals

All goals in a metric must be achieved to be eligible for DSRIP payment (e.g., if a metric has two goals - expanding clinic hours and providing 200 visits - both the expanded hours and 200 visits would need to be completed). Providers should not report a metric as achieved until all goals are fully completed.

- For QPI metrics that include a QPI goal as well as another goal that is not a percentage (e.g., establishing a specialty care clinic), both goals must be completed to be eligible for metric payment. **The provider must report on both aspects of the goal to be eligible for payment.**
- For QPI metrics that include a percentage goal similar to the QPI goal (e.g., percent of target population served, percent increase in number served) as well as the numeric QPI goal, the numeric goal is the primary goal, while HHSC may accept variances in the percentage goal with explanation (e.g., lower than expected denominator size for target population). Please note that these variances do not apply to percentage goals that are part of a QPI designated metric, but not directly related to QPI (e.g., percent of sites with registry functionality, percent of primary care clinics using medical home model). **The provider must report on both aspects of the goal to be eligible for payment.**
- For 4-Year projects with QPI metrics that require a Medicaid/ Low Income Uninsured (MLIU) QPI in addition to the total QPI (designated by a "Yes" in the Medicaid/ Low Income Uninsured cell), both the total QPI goal and the Medicaid/ Low Income Uninsured QPI numeric goal must be met.

While the QPI Reporting Template will generally serve as the only required supporting documentation needed to demonstrate achievement of the QPI-related goal of a metric (see the Project Area Level Guidance section for exceptions), providers will need to submit additional supporting documentation to support other non-QPI related goals included as part of QPI-designated metrics. Also, providers should retain backup documentation to support achievement of all goals, which is subject to compliance monitoring or other audit.

Determining QPI

Defining Individuals and Encounters

HHSC has received a variety of questions regarding the individuals and types of encounters that can be counted towards QPI. The General Guidance section includes broad information about defining individuals and encounters that applies to all or most projects and should be reviewed by all providers. HHSC has also attempted to address QPI as it relates to certain project areas for which we have received many questions. This information can be found in the Project Area Level Guidance section.

Providers should base their QPI submission on the information included in these sections, as well as their metric language and project narrative. Keep in mind that, in general, changes requested through the recent Three-year Project Plan Modification/ Technical Change process (e.g., changes to target population) apply only to DY5 metrics and do not apply to DY3 or DY4 metrics, including those that were carried forward. Approved changes to pre-DSRIP baselines, of course, do apply to all years.

General Guidance

Individuals:

- Individuals must have received a service consistent with the project during the allowable dates of service to be counted.
- For QPI individuals, all persons served through the project during the allowable dates of service should be included, even if those same individuals received services through the project in a prior year.
- Dual eligible patients (Medicare/Medicaid) can be counted towards Medicaid/ Low-Income Uninsured (MLIU) QPI. Medicare only patients should not be counted towards MLIU.
- Ideally, individuals identified as Low-Income Uninsured should be at or below 200% of Federal Poverty Level (FPL) and uninsured.
- Providers may base their MLIU QPI on an individual's payer status at the time of the first project encounter. Therefore, if a client was served through the DSRIP project and was counted as MLIU, and their payer status changed during the waiver, they can continue to be counted.

Encounters:

- A provider may only count encounters if they are providing the visit. They cannot count the encounter if they are simply making a referral, unless this is specifically included as part of their metric language.
- Patient contacts can only be considered as unique QPI encounters wherein a unique service is delivered. Often this can be thought of as a unique billable event. For example, a registered nurse encounter typically is not a service distinct from "visit with physician", so it is considered part of the same visit/service/encounter and counted as one encounter for QPI purposes.
- Telephone calls (including outgoing) may only be counted as a separate QPI events if the call is clinical in nature, the call is specifically related to a project with a goal of telephone outreach, calls are specified in the approved project's metric language / narrative, and the call was completed (e.g., the caller reached the intended person - not just their voicemail - and spoke with them about their care). Outgoing calls that would be appropriate would be a follow-up call to check on a patient's status with symptoms to determine if additional care is needed, a call completed through a nurse advice line created as part of the project, or a follow-up call with a patient who called into the urgent medical advice line. Telephone calls generally are not considered as QPI for other types of projects, such as expanding access to primary or specialty care. Administrative calls, such as satisfaction with services or follow-up as to whether a patient went to the ED or

PCP, would not be appropriate, as they are still part of the same initial encounter. Appointment reminder calls also would not count as QPI encounters.

- Text and email messages generally are not allowable QPI encounters, unless specifically mentioned in a project's metric language/ narrative.
- Group visits may be counted as multiple encounters equal to the number of individuals targeted by the project that attend the group visit.

Project Area Level Guidance

While not all project options are specifically addressed below, HHSC has attempted to include additional information on those for which we have received the most questions. (See the Recommended QPI Metrics by Project Option document for recommended QPIs for project areas not listed below.)

1.1: Expand primary care capacity

Recommended QPI metric: Primary care encounters provided.

- Generally, encounters should only include office visits. They should not include pharmacy visits, lab visits, reminder or follow-up phone calls, etc. that result from or are related to the office visit.
- Visits may include prevention services such as screening for chronic disease, monitoring of disease state markers (e.g. cholesterol levels), and vaccinations.
- Encounters outside of the clinic as part of outreach may be counted towards QPI if they mirror the types and levels of encounters that would be allowable if conducted in the clinic.

1.2: Increase training of primary care workforce

Recommended QPI metric: Primary care encounters provided by residents, trainees, or additional staff (depending on project area option)

- See 1.1.

1.3: Implement a chronic disease management registry

Recommended QPI metric: Individuals managed in registry

- The registry should be designed to allow for the tracking of patient interactions and clinical studies (e.g. lab reports, patient histories) as necessary and pertinent to the DSRIP project. Individuals counted towards QPI should be in the registry and have received some level of interaction during the demonstration year.

1.6: Enhance urgent medical advice

Recommended QPI metric: Urgent care encounters provided

- See 1.1.

1.9: Expand specialty care capacity

Recommended QPI metric: Specialty care encounters provided.

- Encounters should generally only include office visits. They should not include pharmacy visits, lab visits, reminder or follow-up phone calls, etc. that result from or are related to the office visit.

- In most cases, no more than one encounter per unique patient per day should be counted unless a patient saw two different specialists that day for two separate specialty care visits (e.g. a cardiologist and a psychiatrist).

1.10 Enhance performance improvement and reporting capacity

Recommended QPI metric: Individuals positively impacted by improvements

- QPI should equal the number of individuals who experience the improvement(s) in the demonstration year. Individuals must have received some level of service during the demonstration year to be counted.
- The QPI may be equivalent to the total number of individuals served during the demonstration year, or it may be limited to a subset of those served. If the project implemented improvements across the provider's entire system, the QPI would equal the number of patients served by the system in the demonstration year. If the project impacted only patients in one department, for example, the QPI would be limited to the patients served by that department.
- In addition to submitting the QPI Reporting Template showing the number of unique individuals impacted, the provider should also submit documentation that demonstrates that the proposed improvement was achieved.

1.12: Enhance service availability (i.e., hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care

Recommended QPI metric: Individuals receiving community-based behavioral health/ substance abuse services

- For a QPI metric that has a goal of providing behavioral health and substance abuse services, a screening/assessment does not constitute a service. A diagnostic assessment and a diagnosis review would count as a service because the client is already in care. These would have to be updated at regular intervals for all consumers receiving services.

2.1: Enhance/ expand medical homes

Recommended QPI metric: Individuals receiving care under patient-centered medical home model

- Individuals must have received some level of service during the demonstration year to be counted towards QPI.

2.2: Expand chronic care management models

Recommended QPI metric: Individuals receiving care under chronic care model

- Individuals must have received some level of service during the demonstration year to be counted towards QPI.

2.3: Redesign primary care

Recommended QPI metric: Individuals positively impacted by improvements

- See 1.10.

2.4: Redesign to improve patient experience

Recommended QPI metric: Individuals positively impacted by improvements

- For a variety of reasons, it is often not possible to survey every patient seen in a demonstration year to determine whether their personal satisfaction increased. Provided a sampling method that is statistically sound (e.g., a sufficient number of individuals were sampled for the results to be statistically significant, the sampling was random, etc.) is used, individuals that were not surveyed can be counted as those impacted by improvements if they would be expected to also have experienced an improvement in satisfaction during the demonstration year (e.g., they were part of the group targeted by the improvements).
- Individuals must have received some level of service during the demonstration year to be counted.
- In addition to submitting the QPI Reporting Template showing the number of unique individuals impacted, the provider should also submit documentation that demonstrates that there was an improvement in patient satisfaction and an explanation of the sampling method if applicable.

2.5: Redesign for cost containment

Recommended QPI metric: Individuals positively impacted by improvements

- See 1.10.

2.8: Apply process improvement methodology to improve quality/ efficiency (except 2.8.11)

Recommended QPI metric: Individuals positively impacted by improvements

- See 1.10.

2.10: Use of palliative care programs

Recommended QPI metric: Palliative care consults provided

- Consults, as well as additional visits (post consults), may be counted toward QPI if these are included in the project.

2.11: Conduct medication management

Recommended QPI metric: Number of unique individuals receiving medication management services

- Medication management activities may include providing and discussing written materials related to medications with patients to ensure that they understand the purpose of various medications, when they should be taken, consequences of drug omission, precautions related to over-the-counter drugs, toxic side effects, etc.

2.15: Integrate primary and behavioral health care services

Recommended QPI metric: Number of unique individuals receiving integrated physical and behavioral health care

- To be counted towards QPI, an individual must be under the care of both a primary care and behavioral health care provider. Behavioral health services must be provided by a behavioral health provider, like a psychiatrist, psychologist, licensed clinical social worker (LCSW), licensed professional counselor (LPC), or licensed marriage and family therapist (LMFT). Services provided by non-behavioral health providers, even if related to behavioral health, do not meet the criteria for a behavioral health encounter.

Running the Numbers

What is QPI?

HHSC understands that QPI continues to be confusing for some providers. In a nutshell, QPI templates are intended to capture the additional individuals served or encounters provided in a given demonstration year due to the DSRIP project (compared to the service volume that was provided before the DSRIP project was implemented, otherwise known as the pre-DSRIP baseline). QPI metrics are important to help show the impact of DSRIP on healthcare access and quality in Texas, particularly for Medicaid and low-income uninsured individuals.

Determining the Pre-DSRIP Baseline

A general goal of DSRIP is to show increased capacity and enhanced services compared to what existed prior to DSRIP. To determine the level of service that existed prior to the implementation of the DSRIP project, the provider must determine the pre-DSRIP baseline. Every QPI metric will have one (and only one) pre-DSRIP baseline. While the QPI will change from one DY to the next, the pre-DSRIP baseline will not change.

The pre-DSRIP baseline should be calculated based on the number of individuals served or encounters provided in the year prior to the year the DSRIP project started serving individuals. Depending on when a DSRIP project began serving individuals, the pre-DSRIP baseline year might be based on DY1 or DY2 service volume (for providers who have a DY3 QPI metric) or on DY3 service volume (for providers who did not begin seeing clients as part of DSRIP until DY4).

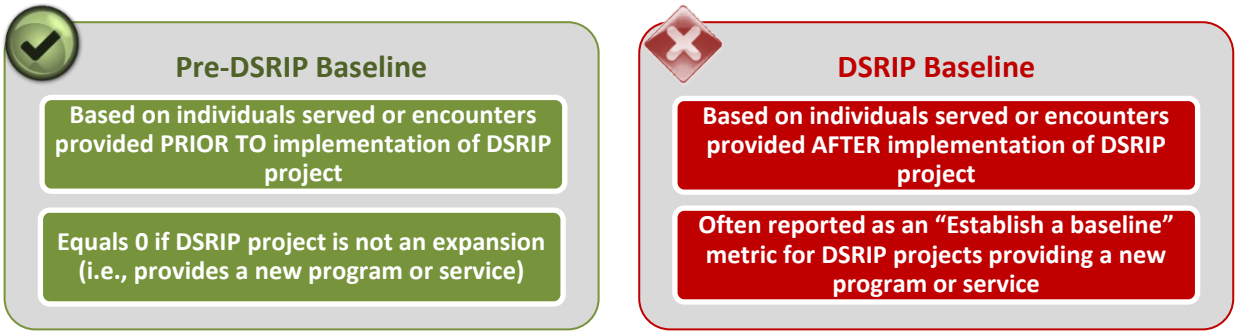
For projects that provide a new program or service (e.g., the opening of a new primary care clinic when no clinics previously existed), the pre-DSRIP baseline would be 0 individuals or encounters. For projects that expand an existing program or service (e.g., increasing hours and staff at an existing primary care clinic), there is a pre-DSRIP baseline greater than 0 that the project seeks to build on (e.g., the number of encounters provided at the clinic prior to the increase in hours and staff). The pre-DSRIP baseline provides the comparison point over the life of the waiver for the level of services provided in any demonstration year. The QPI template will subtract the pre-DSRIP baseline from the total number of encounters or individuals served in a demonstration year to get to the incremental impact of DSRIP. A project's demonstration year goal is the increment above the pre-DSRIP baseline.

The pre-DSRIP baseline should reflect the QPI metric:

- If the project's QPI metric is individuals-based, the pre-DSRIP baseline will be based on the number of unique individuals served during the pre-DSRIP period. If the project's QPI is encounters-based, the pre-DSRIP baseline will be calculated based on the number of encounters provided during the pre-DSRIP period.
- The pre-DSRIP baseline should also reflect the project's goal. If, for example, a provider already operates a primary care clinic that serves patients of all ages, and the goal of the project is to increase primary care capacity for the community by hiring an additional physician, the pre-DSRIP baseline would be the number of primary care clinic office visits provided in the year prior to the hiring of the new physician. If, however, the goal of the project is to increase primary care capacity for children by hiring a pediatrician, the provider may choose to base their pre-DSRIP baseline on the number of primary care clinic office visits provided to children in the year prior to the hiring of the new physician.

When discussing QPI, it is important to distinguish between a pre-DSRIP baseline and a DSRIP baseline. In contrast to pre-DSRIP baseline, which measures service volume PRIOR to DSRIP project implementation (i.e., prior to serving individuals), a DSRIP baseline measures service volume AFTER the project starts serving individuals (typically in the first year of implementation). In their metrics, some providers refer to "establishing a baseline" in

their first year of project implementation and increasing the number of individuals served or encounters provided by X% over the baseline in subsequent years. For example, a project may have a DY2 (non-QPI) metric to establish the first year's number of visits for a new primary care clinic (1000 visits), and then have QPI metrics in DY3-5 to increase that volume by 200 additional visits each year to 1200, 1400 and 1600 visits per year, respectively. In this case, since the 1000 visits in DY2 were provided as part of the DSRIP project, they are considered a DSRIP baseline, and are not the same as the pre-DSRIP baseline that HHSC is requesting when providers report on QPI metrics.



QPI Calculation

To determine the number of individuals served or encounters provided in a given demonstration year (DY) that are a result of the DSRIP project (the QPI), the template will subtract the Pre-DSRIP individuals served/ encounters provided from the total individuals served/ encounters provided in the DY.

HHSC has included some examples of how to calculate QPI below.

QPI Example 1 (New Project - Encounters): A provider is opening its first primary care clinic as part of their DSRIP project during DY2. Consequently, their pre-DSRIP baseline is 0 visits. The clinic provided 1,000 visits in DY2 (its first year of operation as a DSRIP project - so a DSRIP baseline), and the QPI goals are to provide an additional 400 visits over DY2 in DY3, 600 visits over DY2 in DY4 and 800 visits over DY2 in DY5, making the project's QPI goals 1,400 visits in DY3, 1,600 visits in DY4, and 1,800 visits in DY5. In order to meet their QPI metrics, the provider would need to provide 1,400 total visits in DY3, 1,600 in DY4, and 1,800 in DY5.

DY	Pre-DSRIP Baseline	QPI Encounters	Total Encounters
DY3	0	1,400	1,400
DY4	0	1,600	1,600
DY5	0	1,800	1,800

QPI Example 2 (Expansion Project - Encounters): Through their DSRIP project, a provider will expand primary care capacity at an existing clinic by hiring new staff beginning in DY3. The provider provided 1,000 visits in DY2 (the year prior to the clinic expansion), which is the pre-DSRIP baseline. The provider's QPI **goals** are that the new staff

will provide an additional 1,400 visits in DY3, an additional 1,600 visits in DY4, and an additional 1,800 visits in DY5. In order to meet their QPI metrics, the provider must provide a total of 2,400 visits at the clinic in DY3, 2,600 total visits in DY4, and 2,800 total visits in DY5.

DY	Pre-DSRIP Baseline	QPI Encounters	Total Encounters
DY3	1,000	1,400	2,400
DY4	1,000	1,600	2,600
DY5	1,000	1,800	2,800

QPI Example 3 (New Project - Individuals): A new diabetes care management program is being established through DSRIP, so the pre-DSRIP baseline is 0 individuals receiving care under the chronic care model. Through DSRIP, the project plans to serve 50 patients in DY2 (a non-QPI metric), and enroll 50 more patients in the program in each subsequent DY, making the QPI goals 100 individuals receiving care under the chronic care model in DY3, 150 individuals receiving care in DY4 and 200 individuals receiving care in DY5. To meet their QPI metrics, they must provide care to 100 unique individuals in DY3, 150 in DY4, and 200 in DY5.

DY	Pre-DSRIP Baseline	QPI Individuals	Total Individuals
DY3	0	100	100
DY4	0	150	150
DY5	0	200	200

QPI Example 4 (Expansion Project - Individuals): A diabetes care management program is being expanded through DSRIP. Prior to DSRIP, in DY2, a hospital had a care management program that served 50 individuals with diabetes each year (the pre-DSRIP baseline). Beginning in DY3, the hospital intends to enroll 50 additional patients to the program in each DY as part of their project, making the QPI goals 50 additional individuals served in DY3, 100 in DY4, and 150 in DY5. To meet the QPI metrics, the provider will have to serve a total of 100 individuals in DY3, 150 in DY4, and 200 in DY5.

DY	Pre-DSRIP Baseline	QPI Individuals	Total Individuals
DY3	50	50	100
DY4	50	100	150
DY5	50	150	200

QPI Reporting Template

How the Template Calculates QPI and Why

The QPI Template calculates QPI by subtracting the annualized pre-DSRIP service volume (either individuals served or encounters provided) entered in Step 5 from the total service volume (individuals or encounters) entered in Step 6. Below is a detailed explanation of how the QPI Template calculates QPI (with the example focusing on DY3 QPI) and why this is the case.

QPI is intended to measure the service volume provided during the eligible dates of service that is a result of implementing the DSRIP project. Step 5 in the QPI Template is used to determine the pre-DSRIP baseline. Again, the pre-DSRIP baseline is intended to show that, prior to the DSRIP project serving individuals, the provider had the capacity to serve X number of individuals or to provide X number of encounters per year. This is the service capacity one would expect the provider to have in DY3 if the DSRIP project had not been implemented. So, for

example, if a provider operates a primary care clinic with 2 PCPs and is implementing a DSRIP project to increase primary care capacity by hiring 1 additional PCP, their pre-DSRIP baseline would equal the number of encounters (in this case, office visits) provided by the 2 existing PCPs during the year prior to the date the new PCP was hired. One would expect that at a minimum this service volume would continue after the implementation of the DSRIP project. The QPI Template will already include the pre-DSRIP baseline if QPI has previously been reported for achievement.

Step 6 is used to calculate the total service volume actually provided in a DY. In this step, the provider pastes records for all of the individuals served/ encounters provided relative to the project during a DY (or the allowable date range). (If a provider implemented a system to track individuals served or encounters provided by the DSRIP project expansion separately from individuals served or encounters provided outside of the DSRIP project, they will need to combine these two data sources to get the total number of individuals served or encounters provided within the DY date range.) To be clear, Step 6 **should include all individuals served or encounters provided relative to the project, whether the individuals/ encounters are due to the DSRIP expansion or due to capacity that was in place prior to DSRIP project implementation**. So, in the example above, in Step 6, the provider should include all of the office visits provided in DY3, those that were provided by the 2 PCPs that were on staff before the DSRIP project was implemented and those provided by the newly hired PCP.

The template calculates the total DY service volume based on what was entered into Step 6 in one of two ways, depending on the project's QPI grouping. If the QPI grouping is encounters, the template counts each encounter entered in Step 6 that is between the date range as one encounter and adds those up. If the grouping is individuals, the template takes only the encounters that fall within the DY date range and determines, based on patient ID, how many unique individuals were served in the DY.

The template then takes the total service volume calculated based on Step 6 and subtracts the annualized pre-DSRIP service volume entered in Step 5. What is left is the QPI - or the service volume due to the DSRIP project. This number must equal or exceed a project's QPI goal for the metric to be considered achieved. So, in the example above, assume the pre-DSRIP baseline was 2,000 encounters (each PCP provided 1,000 office visits during the year prior to hiring the new PCP), which was entered in Step 5. Also, assume that, in DY3, the 3 PCPs together provided 3,100 office visits, and these records were pasted into Step 6. The QPI (or the service volume in DY3 that can be attributed to the DSRIP project) calculated by the template would be 1,100 (3,100 total office visits minus 2,000 pre-DSRIP baseline office visits).

Step-by-Step Instructions for Completing the Template

Note: In this section, provider actions will be in red font.

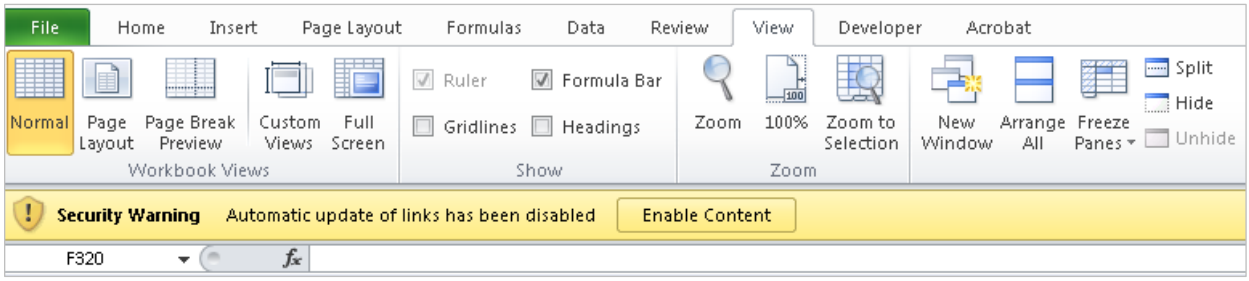
Providers should only submit one QPI Reporting Template per project. The template will serve to meet both metric achievement and SAR requirements for DY3, DY4, and DY5.

The QPI Template relies on a number of complex calculations and macros to operate correctly and is password protected for this reason. Providers should not attempt to bypass the password or alter the template in any way. If a provider believes the template is operating or calculating incorrectly, please refer to the section of this document that addresses the step causing the issue as well as the Troubleshooting section. If your issue is not addressed in this document, please contact HHSC for assistance.

In the template, provider entries are highlighted in yellow. Blue text indicates information that is auto-filled based on previous provider inputs. Information entered into QPI templates submitted in previous reporting (or corrected through technical assistance with HHSC) will auto-fill into the October DY4 QPI template.

Please note that the instructions below sometimes differ based on whether or not, in addition to a DY5 QPI metric, a provider has a DY4 QPI metric that was carried forward. Please be sure you are following the instructions that pertain to your project's situation.

To ensure the QPI Reporting Template's interactive features work properly, be sure to click the *Enable Macros* button if it pops up upon opening the file (see image below). Also, confirm that workbook calculations are set to *Automatic*. (Under the *File* tab in Excel, click *Options*, followed by *Formulas*. Under *Calculation Options*, select *Automatic* for *Workbook Calculation*.)

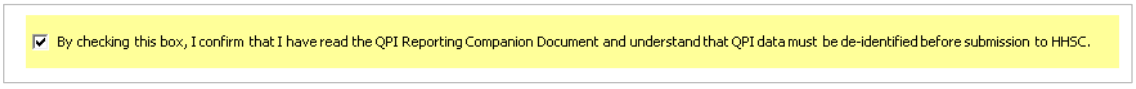


To help ensure that identifying patient information is not transmitted to HHSC, providers will not be able to save the QPI Reporting Template until the last step (Step 9: De-Identifying Patient IDs) is completed for the DY for which the provider is reporting. As such, **HHSC recommends providers complete the template in one sitting if possible.** Providers should also consider running the client database query (see Step 6) prior to entering any information into the QPI template.

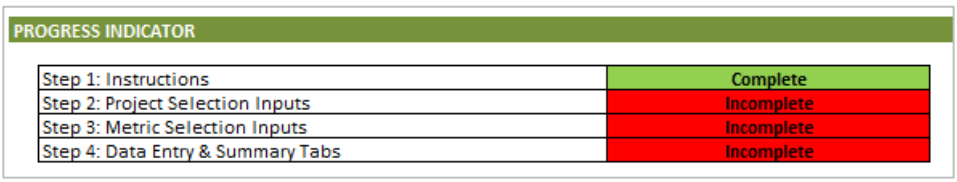
Instructions tab

Step 1:

Before entering any information in the QPI Reporting Template, carefully read the *QPI Reporting Companion Document*. The Instructions tab in the QPI Reporting Template also includes general instructions included in the *QPI Companion Document* and may be used as a quick reference while completing the template. Check the yellow box at the bottom of the Instructions tab (see image below) to confirm you have read the *Companion Document* and that you understand that QPI data must be de-identified prior to submission to HHSC.



Checking the box on the Instructions tab will change your progress for "Instructions" on the Project Data Entry tab from a red Incomplete to a green Complete.



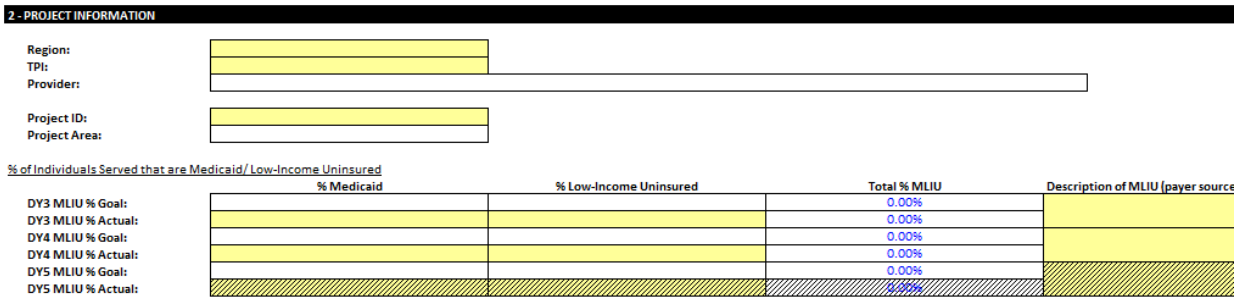
Project Data Entry tab

Providers will enter general provider, Medicaid/ Low-Income Uninsured (MLIU), and QPI metric information on the Project Data Entry tab.

Step 2:

Project Information:

Under Step 2 (see image below), providers will select their region (RHP) number, their TPI and the project's ID from the dropdown menus.



Making these selections will complete auto-filled cells with the project's MLIU and QPI goal information in the QPI Template. In addition, providers with a DY3 QPI metric will see the previously reported information auto-fill in the DY3 cells. Providers without a DY3 QPI metric will see grayed out cells for DY3.

Medicaid/ Low-Income Uninsured (MLIU) Percentages:

Enter the percentage of Medicaid and Low-income/uninsured population your project has served in the open % Medicaid and % Low-Income Uninsured. This information for your project should be updated each time you report QPI, which must be at least once each demonstration year. The percentages should reflect the individuals served by your project between the encounter dates you are using to report that DY's QPI (i.e., dates entered in Step 7).

- Projects with a DY4 Carryforward QPI Metric: Providers who requested carryforward for a DY4 QPI metric and did not report on that metric for achievement in April 2016 will need to report both their DY4 MLIU and their DY5 MLIU percentages to date.
- Projects without a DY4 Carryforward QPI Metric: Providers who did not request carryforward for a DY4 QPI metric will only need to report MLIU percentages for DY5 to date. The DY5 MLIU percentages should be based on the individuals served by the project between October 1, 2015 and September 30, 2016.
- Providers who previously reported for achievement of DY5 QPI metrics in April 2016 should update the MLIU data fields and description for the full demonstration year of data for DY5 for SAR purposes.
- Be sure to review the instructions under Step 7 for directions on how to determine the date ranges for MLIU percentages.

The combined MLIU percentage will be calculated for you. Enter a description of the MLIU that includes the basis of your percentage: payer sources that are included, income levels, and other helpful information. If your total MLIU percentage is more than 20% lower than the total MLIU goal, the combined MLIU will be red, **and you will need to include an explanation of why this is the case in the description box**. Descriptions may not include "Not

Applicable" and should indicate the population you are counting in your MLIU percentages (i.e. CHIP, Medicaid, Dual-eligibles, uninsured, self-pay, etc.)

While MLIU data reporting is required in the QPI Template, providers do not have to meet the MLIU percentage goals to achieve QPI metrics, and supporting documentation does not need to be submitted during reporting to support the MLIU percentages you enter. However, this information is auditable by the compliance monitor. As such, a provider should maintain all relevant supporting documentation. ~~and the compliance monitor will be notified of providers whose MLIU percentages are significantly lower than their goals.~~ In addition, if your project has an MLIU QPI requirement, your MLIU QPI metric achievement should be similar to the achieved MLIU percentage multiplied by the achieved total QPI.

Once Step 2 inputs are complete, the "Project Selection Inputs" Progress Indicator will change to Complete.

Step 3:

The Template allows a provider to report up to three QPI metric sets (a set of DY3, DY4, and DY5 QPI metrics with similar goals) to accommodate projects with multiple QPI metrics in a DY. Step 3 (see image below) will show up to three sets of input boxes, based on the number of metric sets a project has. Projects with more than one QPI metric in a DY should repeat the instructions below for each metric.

3 - QPI METRIC SELECTION

QPI Metric #1

	DY3	DY4	DY5
QPI Metric ID:		I-12.1	I-12.1
Metric Language:		Baseline: 420 Gero psych telemedicine visits (2012). Goal: 1,000 telemedicine program visits (encounters).	Baseline: 420 Gero psych telemedicine visits (2012). Goal: 1,150 telemedicine program visits (encounters) in DY5.
Metric Grouping		Encounters	Encounters

	DY3	DY4	DY5
Metric Achievement Reporting Status:		Reporting DY4 metric achievement as carryforward	
Metric-Level SAR Reporting Status:		Reporting QPI for Oct DY4 SAR purposes	Reporting QPI for Oct DY5 SAR purposes
QPI Goal:		1,000	1,150
QPI Actual (Provider Calculation):		1,000	

	DY3	DY4	DY5
MLIU QPI required?		No	No
MLIU QPI Goal:			
MLIU QPI Actual:			
Revise the MLIU QPI description for this metric, if it differs from the project-level description inserted from your entry above:			

Metric Achievement Reporting Status:

In order for the QPI template to work properly (i.e., lock when reporting on a DY is completed, but remain unlocked when reporting on a DY has not been fully completed), providers need to carefully select a Metric Achievement Reporting Status from the dropdown list for all open (i.e., not grayed out) DYs.

If a provider does not have a QPI metric for a particular DY, "NA - No QPI metric in DY#" will be listed as the Metric Achievement Reporting Status. If a provider does have a metric for the DY, the Metric Achievement Reporting Status options will include those listed below (with the # sign listed below referring to the QPI metric's DY). The options that are available for selection by the provider are dependent upon whether the QPI metric is a current year metric or a carryforward metric. QPI metrics that have not previously been reported on for metric achievement will be blank when the template is auto-filled, and provider input cells for these metrics will be unlocked.

- Not ready to report DY# metric achievement:
    - If the provider will not be able to achieve the DY4 carryforward metric and will forfeit their DY4 payment for the metric, the provider should select “Not ready to report DY4 Metric achievement”. The provider should also confirm in the progress update fields of the online reporting system that they intend to forfeit achievement of the DY4 metric.
    - A provider should choose this status if they are not ready to report for achievement in DY5 and are only reporting to meet SAR requirements.

- Reporting DY# metric achievement as carryforward:
    - This Metric Achievement Reporting Status will only be available for metrics that were carried forward from the prior demonstration year. In October DY5, this applies to DY4 carryforward metrics.
    - When a provider who requested carryforward for their DY4 metric is ready to report their metric for achievement, they should select “Reporting DY4 metric achievement as carryfoward”.
    - If a provider made this selection during April DY5 reporting, their DY4 metric will be locked during October DY5 reporting and no additional information on this metric is necessary.

- Reporting DY# metric achievement in DY# reporting period:
    - QPI metrics that were reported on for achievement during DY3 or DY4 reporting period will show this Metric Achievement Reporting Status when the template is auto-filled, and provider input cells for this metric will be locked.
    - This Metric Achievement Reporting Status option will only be available in the dropdown box for current demonstration year metrics (i.e., for DY5 metrics). It will not be available for DY4 carryforward metrics.
    - When a provider is ready to report a DY5 QPI metric for achievement, they should select “Reporting DY5 metric achievement in DY5 reporting period” as their Metric Achievement Reporting Status.

- Reporting DY5 metric for achievement, but forfeiting DY4 metric achievement:
    - As mentioned above, if the provider will not be able to achieve their DY4 metric goal by the end of the carryforward period (September 30, 2016) and will forfeit payment for that metric, the provider should leave the reporting status as "Not Ready to Report DY4 metric achievement."
    - The provider is still required to enter the number of individuals/patient encounters in Step 6 under DY4 to indicate the number of individuals/patient encounters that did occur during the regular DY4 period (October 1, 2014 (or after the DY3 carryforward achievement date, if applicable) to September 30, 2015) and fill out the appropriate information in Step 7. The provider should not include any encounters beyond the end of DY4 (September 30, 2015) in order to count the DY5 QPI from the beginning of DY5 (October 1, 2015).
    - The provider may begin the QPI count toward their DY5 QPI goal (whether for SAR purposes or reporting for achievement) from the beginning of DY5 (October 1, 2015).

<u>Metric–level SAR Reporting Status:</u>

All providers with a QPI metric in a demonstration year (DY) are required to submit a QPI Template for SAR purposes in October of that DY. To keep the QPI Template from locking before SAR is reported, the proper

selection(s) for the Metric-level SAR Reporting Status as well as the Metric Achievement Reporting Status are required. HHSC has worked with our contractor to automate the selection of the Metric-level SAR Reporting Status, so provider input is no longer needed here.

- For DY3 and DY4 carryforward metrics, the QPI template was required for SAR reporting purposes during October DY3 and October DY4 reporting, respectively, and will not need to be submitted for these purposes in DY5. The DY3 SAR Reporting Status will show "Reporting QPI for Oct DY3 SAR purposes", and the DY4 SAR Reporting Status will show "Reporting QPI for Oct DY4 SAR purposes".
- For all DY5 metrics, the QPI template is required for SAR reporting purposes during October DY5 reporting. As such, "Reporting QPI for Oct DY5 SAR purposes" will show under DY5 during October DY5 reporting. Even if a provider previously reported for achievement of their DY5 metric in April, they will need to fill out the QPI template with updated data -- MLIU and patient encounters and relevant dates (reporting through September 30, 2016)-- for the purposes of SAR.

QPI Actual:

Providers reporting on a DY's QPI metric should enter the QPI Actual for each open DY (even if they are forfeiting their DY4 metric). The QPI Actual, also referred to as the Provider Calculation, is the total number of DY encounters/individuals served minus the pre-DSRIP baseline. It should be based on the data entered in Step 6 and the dates entered in Step 7. If you are reporting for metric achievement and believe your metric should be approved for payment, this number should equal to or be greater than the QPI goal. If you are not yet ready to report for achievement (i.e., you are reporting a DY4 metric as carryforward, but have not yet achieved your DY5 QPI metric), the QPI Actual can be lower than the QPI goal. Remember, a provider should update this field with DY5 data through September 30, 2016 for DY5 SAR purposes, even if the DY5 metric was previously reported for achievement. Please note that the QPI Actual is what is referred to as the Provider Calculation on the Metric QPI Summary Tab that is created during Step 4.

MLIU QPI:

In addition to the total QPI goal referenced above the QPI Actual, some projects must meet a Medicaid, Low-Income Uninsured (MLIU) QPI. If MLIU QPI Required equals "No", a MLIU QPI is not required and this step can be skipped. If MLIU QPI Required equals "Yes", this section is required.

MLIU QPI represents the number of individuals served that were MLIU or the number of encounters provided to individuals that are MLIU (based on the QPI metric grouping). **As such, providers should be entering whole numbers, not percentages, into these cells.** In addition, because MLIU QPI is a subset of the total QPI, the MLIU QPI Goal should not exceed the Total QPI Goal auto-filled for the metric, and the MLIU QPI Actual should not exceed the Total QPI Actual entered by the provider in the cell above.

To enter the MLIU QPI goal, the provider should find the MLIU QPI goal listed in the provider's QPI metric. This goal is typically found in the metric's baseline/ goal statement, but may be included in the milestone or metric description language. If the MLIU QPI goal is listed as a percentage in the metric language, the provider will need to calculate the numeric MLIU QPI Goal by multiplying the Total QPI Goal by the MLIU percentage goal listed in the metric (e.g., if the provider's total QPI goal is 100 individuals and the MLIU QPI goal is 80%, the MLIU QPI numeric goal would be 80 individuals).

Next, the provider will enter the MLIU QPI achieved. Like the total QPI achieved, the MLIU QPI should not include the pre-DSRIP baseline. The MLIU QPI should be similar to the total QPI achieved that was reported in the QPI

Actual cell times the Total MLIU % reported in Step 2 (e.g., if the total QPI is 100 and the MLIU % is 90%, the MLIU QPI should be 90).

The box below the MLIU QPI Actual will auto-fill with the DY's MLIU percentage description entered in Step 2. Generally, the description should be the same for overall MLIU % and MLIU QPI. If for some reason the descriptions differ (which may be the case if a provider has more than one QPI metric in a DY), please update the cell under Step 3.

Once you complete all inputs under Step 3, "Metric Selection Inputs" under the Progress Indicator will change from a red Incomplete to a green Complete.

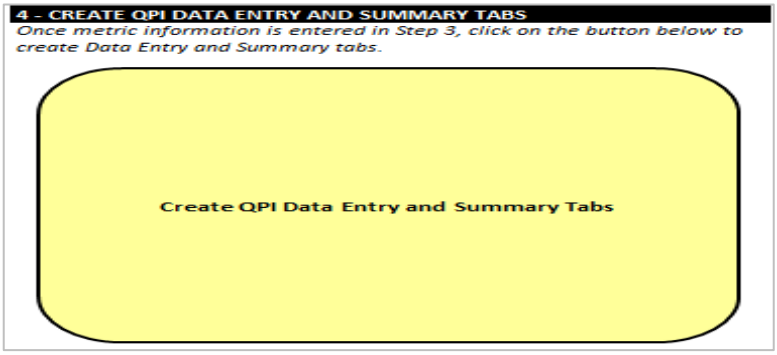
Step 4:

Once steps 1 - 3 are complete, click on the "Create QPI Data and Summary Tabs" button (see image below). You will receive a pop-up warning if any of Steps 1-3 are incomplete, and you will not be able to create the new tabs until they are complete.

You will also receive a pop-up reminder asking you to check the selection of the *Metric Achievement Reporting Status*. Once you have created the metric-tabs, you will not be able to change the *Metric Achievement Reporting Status* selection. If you have made an error in the *Metric Achievement Reporting Status* selection and want to change it, select "no" and make your changes. Once you have created the metric data entry tabs, if you find you have made an error in the *Metric Achievement Reporting Status* selection, you will need to download a new QPI template and start again.

Once you have confirmed your *Metric Achievement Reporting Status* is correct, click "yes". Two new tabs for each QPI metric set will be created.

Proceed to the QPI Data Entry tab.

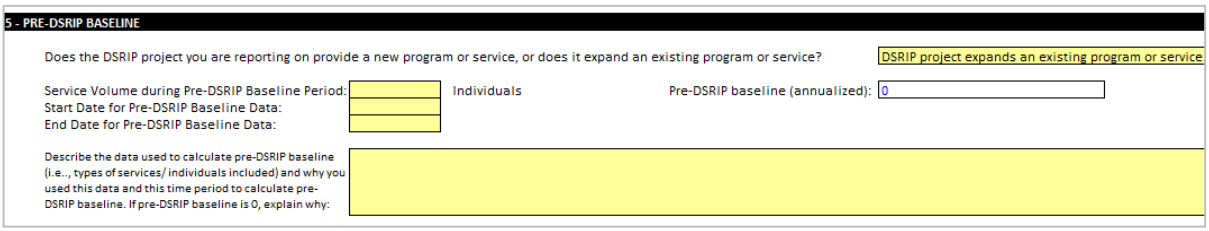


QPI Data Entry tab

Step 5:

When completing the QPI Reporting Template for the first time for any metric, the provider must provide information regarding the pre-DSRIP baseline in Step 5 (see image below). Providers who completed a QPI template in the past (i.e., providers with projects with a DY3 or DY4 QPI metric that was reported for achievement) cannot complete this step again. Once a QPI metric in the metric set is reported for achievement, Step 5 is locked and editing is not possible.

- For DY3 and DY4 QPI metrics previously reported for achievement, Step 5 will include the previously entered data, and providers will not be able to edit this information. For these metrics, the provider should proceed to Step 6.
- For projects without a DY3 metric and for which DY4 QPI metrics were reported for Semi-Annual-Reporting purposes in October DY43 reporting, but not reported for achievement (i.e., carried forward metrics), Step 5 will include the data entered during DY4, and this information will not be locked. Providers should only make changes to Step 5 pre-DSRIP information if they were unable to provide information based on 12 months of data when they last reported, because they had not yet started seeing individuals, or if this section included an error. Any boxes changed by the provider will highlight green. The provider should explain the reasons behind any changes in the description box included in this Step.
- For QPI metric sets that did not include a DY3 or DY4 QPI metric, Step 5 will be blank, and the provider will need to complete this section.



Providers who are entering information into Step 5 should carefully read the Determining the Pre-DSRIP Baseline section of this document to confirm that they are correctly entering their pre-DSRIP baseline information, and that they understand the difference between the pre-DSRIP baseline required here and a DSRIP baseline, which should not be entered here.

In the dropdown box in Step 5, providers will indicate whether their "DSRIP project provides a new program or service" or their "DSRIP project expands an existing program or service". If the project provides a new program or service, the pre-DSRIP baseline service volume and dates will gray out and the annualized pre-DSRIP baseline will auto-fill to 0. If the project is an expansion, the provider will need to enter the pre-DSRIP baseline that they calculated for their project, as well as the dates used for the calculation. Only projects that provide a new program or service should have a pre-DSRIP baseline equal to 0, while projects that expand an existing program or service should have a pre-DSRIP baseline greater than 0. As such, providers should not select “DSRIP project expands an existing program or service” and enter 0 into the Service Volume During Pre-DSRIP Baseline Period cell.

Whenever possible, providers should use 12 months of data immediately preceding the implementation of the DSRIP project (i.e., the time when the project began to serve individuals) to calculate their pre-DSRIP baseline. If a project begins seeing patients on November 1, 2014, for example, the provider could base their pre-DSRIP baseline on the service volume (encounters provided or individuals served depending on their QPI metric grouping) between November 1, 2013 and October 31, 2014. If the provider is not able to obtain dates exactly one year prior to the date of implementation, they may submit data from a period close to these dates (e.g., their fiscal or calendar year data) that is more readily available. The pre-DSRIP baseline date range cannot overlap with the QPI DY date range the provider will provide in Step 7.

If a provider is unable to obtain 12 months of data on which to calculate the pre-DSRIP baseline, the template will calculate an annualized pre-DSRIP baseline based on the data entered. If you are having issues with the annualization of your pre-DSRIP baseline, please see the Troubleshooting section of this document.

In the space provided, all providers should provide a description of the data used to determine their pre-DSRIP baseline (including the target population, the types of encounters included, etc.) and the reason the date range for the calculation was used. If the provider did not use 12 months of data to calculate their pre-DSRIP baseline and/ or did not use 12 months immediately preceding the implementation of their project, they should provide justification here. If a provider's pre-DSRIP baseline is 0, they should clearly explain why they consider their project to be a new project and not an expansion. If the pre-DSRIP baseline entered in the QPI Template differs from what is included in the project narrative or in the metric baseline/ goal statement(s), providers should also include an explanation for this change in this box.

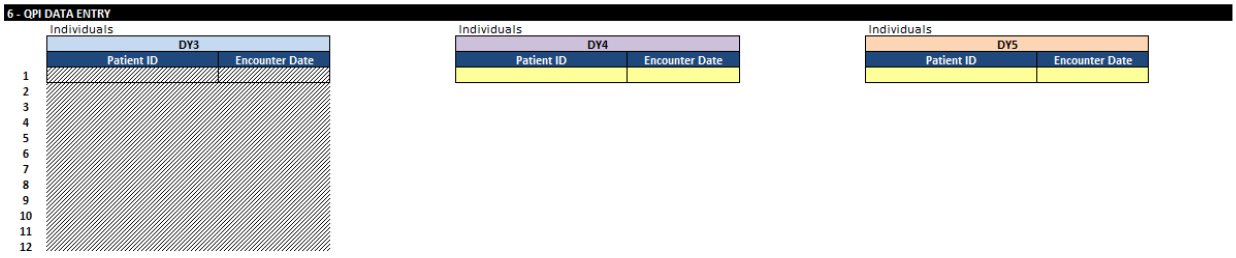
HHSC is not asking providers to submit supporting documentation or data to demonstrate the calculation of their project's pre-DSRIP baseline. However, this information, like all information submitted for reporting, is auditable by the compliance monitor.

Step 6:

In order to properly document and calculate QPI achievement, HHSC is asking providers to paste patient ID and encounter date data from their EHR system, client database, or spreadsheet into Step 6 (see image below). Please note only the first cells of the columns for provider data input are outlined and highlighted in yellow. However, the provider is still able to paste up to 530,000 patient encounters. Providers will enter both patient and encounter data regardless of their QPI metric grouping.

HHSC recognizes that each provider has their own unique way of collecting data, so we've kept flexibility in mind when designing the QPI Reporting Template.

- Patient IDs can include letters, numbers, or a combination of both and must be inputted such that unique individuals have unique IDs. The provider is ultimately responsible for ensuring that the data submitted to HHSC excludes confidential or personally identifiable information. Providers should not use names, as scrambling methodologies may not be sufficient to adequately de-identify certain names. When possible, providers should assign more generic values to individuals (e.g., Patient 1, Patient 2, etc.) or assign a de-identifiable patient ID PRIOR to pasting this type of information into the QPI Template. As a cautionary step, the template includes a de-identification macro (Step 9) that applies scrambling methodologies to the inputted Patient ID data. Prior to template submission, the provider must review the patient IDs to ensure that the final data submitted excludes confidential or personally identifiable information.
- Encounter dates need to include month, day, and year. If a provider has only tracked encounters by month or quarter, for example, they may assign a date (e.g., the first or last day of the month or quarter) as the encounter date, but should include how the encounter dates were assigned when they describe their QPI data in Step 7.



In order to obtain the data you want to paste into the QPI Reporting Template, follow the steps below:

1. Run a query from provider's data source that includes patient ID and encounter date variables and reflects the QPI metric and pre-DSRIP baseline data the provider submitted:

    - Providers will need to limit the query to the types of encounters and that are relevant to the DSRIP project based on the project option, metric ID, and metric language. A primary care (1.1) project, for example, should typically only include office visits (and not appointment reminder calls, lab visits, etc.) in their query. Please refer to the Defining Individuals and Encounters section of this document, as well as the QPI metric language when determining the patient contact types to include in your query.
    - Providers will also need to limit the query to the types of individuals that are relevant to the DSRIP project. For example, if a provider's goal is to increase the number of women served, the query should be limited to women.
    - Providers will also need to limit the query to the appropriate dates. See Step 7 for instructions on determining start and end dates for your Step 6 data.

    The resulting query should be similar to the sample on the right where each encounter date is a separate record and patient IDs are repeated if an individual has received more than one encounter.

Patient ID	Encounter Date
Client01	10/1/2013
Client02	10/22/2013
Client02	12/3/2013
Client03	11/4/2013
Client04	1/25/2014
Client05	4/17/2014
Client05	7/8/2014
Client06	6/28/2014

2. Once the provider has run a query limiting the data to the appropriate encounters, individuals, and date parameters, they should highlight and copy the data from the query, so it can be pasted into the QPI Reporting Template. If the query includes the Patient ID and Encounter Date fields side by side and in the same order as they are in the QPI Reporting Template (i.e., Patient ID in the first column, Encounter Date in the second column), the provider can highlight and copy all of the data in these two columns (minus the field names). If the query does not display the fields side-by-side and/ or does not display them in the same order as the template, the provider will need to copy and paste the data from each field one at a time.
3. Once the provider has highlighted and copied the data (minus the field names) from the query, return to the QPI Data Entry tab of the QPI Reporting Template, and find the columns that correspond with the DY of the metric on which you are reporting. If you are reporting on a DY3 carryforward QPI metric, this will be DY3. If you are reporting on a DY4 QPI metric, this will be DY4.
4. Right click on the first cell highlighted yellow in the applicable DY's Patient ID column (or the Encounter Date column if you're pasting fields one-by-one) under the DY that corresponds to the QPI metric on which you are reporting and select **Paste Values**. Please be sure to use the Paste Values, as the template will not calculate properly if the data checking and formatting functions are overridden. . If the Paste Values option is not available, please select Match Destination Formatting when pasting data.

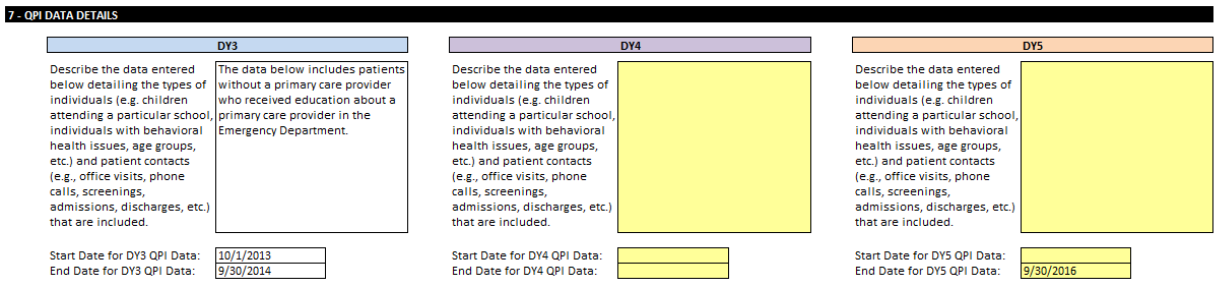
Please note that the QPI Reporting Template can accommodate up to 530,000 encounters in each demonstration year. If you have a large number of records, it may take some time to paste all of the data. Please be patient and do not attempt to do any other actions in the template until the paste is complete. If a provider's query returns more than 530,000 records for a demonstration year, please email the Waiver mailbox to discuss how to report QPI in that year.

All providers need to input data into Step 6 for DY5 for SAR purposes, even if the provider previously reported for completion of a DY5 metric in April or is not ready to report in DY5. The progress indicator will remain red and incomplete until step 6 is completed.

Step 7:

Description of Data Entered in Step 6:

Once Patient ID and Encounter Date data have been pasted into the template, providers will need to describe the data that was pasted into the spreadsheet in the box provided in Step 7 (see image below).



In the text box, specify:

- the types of encounters (e.g., office visits, nurse line calls completed, screenings, pharmacy consultations, etc.) included in the data; and
- the types of individuals (ages, diagnoses, discharges, etc.) included in the data.

Please be as detailed as possible. Providers who do not provide adequate detail may receive a request for additional information to confirm QPI is being calculated correctly, which will result in delay of payment of the metric.

Start and End Dates for Step 6 Data:

In Step 7, providers will also need to enter the date ranges for QPI encounters included in Step 6. Start and end dates must fall within the allowable dates of service for the metric's DY. The table below outlines the allowable dates of service as they apply to October DY5 Reporting period:

QPI Metric DY	Start Date Rules	End Date Rules
DY4 (Carryforward)	▪ After Step 5 end date if no DY3 metric ▪ Between 10/1/14 or DY3 Carryforward End Date & 9/30/16	▪ After DY4 Step 6 Start Date ▪ Between 10/1/14 or the DY3 Carryforward End Date & 9/30/16
DY5	▪ After Step 5 end date ▪ Between 10/1/15 & 9/30/16 ▪ **On** or after DY4 Carryforward End Date	▪ After the DY5 Step 6 Start Date ▪ Between 10/1/15 or the DY4 Carryforward End Date & 9/30/16

The template will allow the End Date for a DY4 Carryforward metric to be the same as the Start Date of a DY5 metric. It will not allow a gap between these dates. Because of these restrictions, if you enter dates into Step 7 and need to edit the DY4 Carryforward End Date or DY5 Start Date, you should delete the entries and start again. The template has auto-filled the DY5 End Date.

Please do not include encounters that occurred after September 30, 2016 in Step 6 or include an end date after September 30, 2016 in Step 7 during October DY5 reporting.

IMPORTANT INFORMATION FOR PROJECTS WITH DY4 CARRYFORWARD QPI METRICS: Encounter dates that occur on or before the DY4 carryforward Step 6 End Date noted above are applied toward DY4 QPI and cannot be

counted towards DY5 QPI. As such, providers with DY4 carryforward QPI metrics should be very selective when choosing their carry forward DY4 QPI End Date. Providers are encouraged to enter the earliest DY4 End Date possible that allows them to achieve their exact DY4 QPI goal, so that encounter dates that are not needed to achieve their DY4 QPI goal are counted towards their DY5 QPI. A provider may include more encounters in their DY4 achievement than are necessary to meet their DY4 goal, but know that they will not be able to use those encounters toward meeting the DY5 goal.

QPI Summary tab

Step 8:

Once the provider enters their information on the QPI Data Entry page, but before they click the Step 9 button to de-identify the information they entered, they should go to the QPI Summary tab to view the QPI Template calculations. Clicking on the summary tab will start the QPI data match calculation.

QPI calculations will be based on the project's QPI grouping. If the grouping is encounters, all encounters within the Start and End Dates specified in Step 7 will be counted. If the grouping is Individuals, the number of unique individuals (i.e., unique Patient IDs) with encounters within the date range will be calculated. The QPI will equal the total eligible encounters provided or individuals served minus the pre-DSRIP baseline. (See the QPI Calculation section of this document for more information.)

The provider should view the Data Calculation Match Indicator (see image below) on the QPI Summary tab to confirm that the QPI Template calculation matches what the provider entered as their actual QPI on the Project Data Entry tab (also referred to as the Provider Calculation).

DATA CALCULATION MATCH INDICATOR

Year	Actual QPI Individuals		
	Provider Calculation	Template Calculation	Calculations Match
DY3	1,705	1,705	Yes
DY4	5	5	Yes
DY5	5	5	Yes

If the template calculation matches the provider entry, the Calculations Match column will indicate "Yes" in green. If there is a discrepancy between the template calculation and the provider entry, the provider will see a red "No" the Calculations Match column.

If the template calculation and the provider entry do not match, the provider should carefully review the Running the Numbers section of this document to be sure they understand how QPI is calculated through the template. The provider should also re-read the Step-by-Step Instructions and check template inputs to confirm data was correctly entered. Finally, providers should reference the Troubleshooting the QPI Template section in this document for tips for resolving common issues. During review, HHSC finds QPI template calculations to be highly reliable and believes that the vast majority of provider/ template calculation discrepancies can be resolved by providers reviewing the referenced sections.

It is important that the provider and HHSC agree upon the QPI achieved by the project, since this information will likely be used in future analyses and data requests. **Please attempt to address any discrepancies so that the Calculations Match box shows a green Yes.** If after further review, the provider finds that the value they entered

on the Project Data Entry tab as the Actual QPI (i.e., the provider calculation) is incorrect, please return to that tab and change the QPI Actual to the correct number. If the provider finds that the provider calculation is correct, but information was incorrectly entered into the template, please correct the provider inputs, so that the QPI calculation is corrected.

After taking these steps, if the provider is still unable to reconcile provider and template discrepancies (i.e., template and provider calculations still do not match), please provide a detailed explanation of how provider entries were calculated in the Step 8 comment box on the QPI Summary tab. In addition, the provider should submit DE-IDENTIFIED supporting documentation (see the October DY4 Reporting Companion Document for more information) that clearly supports the provider's calculation, along with the QPI Template, to HHSC through the online reporting system.

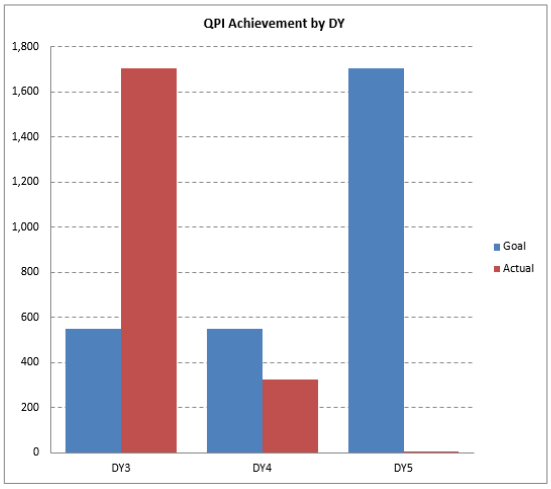
QPI PROGRESS SUMMARY (based on template calculations)

PROJECT INFORMATION	
Region:	RHP 1
TPI:	094095902
Provider:	The Good Shepherd Hospital dba Good Shepherd Medic
Project ID:	094095902.2.1
Project Option:	2.9

METRIC INFORMATION		
DY3	I-6.2	550 individuals served. 10% - Numerator: Number of ED patients without a PCP documented in their medical record that receive (documented) education or resources to identify a PCP from a patient navigator. Denominator: ED patients without a PCP documented in their medical record.
DY4	I-6.2	10% Percent of patients without a primary care provider (PCP) who received education about a primary care provider in the ED. Goal is to serve 550 individuals Numerator: Number ED patients without a PCP documented in their medical record that receive (documented) education or resources to identify a PCP from a patient navigator. Denominator: ED patients without a PCP documented in their medical record.
DY5	I-6.2	DY5 impact of 1,705 individuals.
Grouping	Individuals	

REPORTING DETAILS	
DY3	Reporting DY3 metric achievement in DY3 reporting period
DY4	Not ready to report DY4 metric achievement
DY5	Not ready to report DY5 metric achievement

Year	Total QPI		METRIC ACHIEVEMENT	MLIU QPI Required?	MLIU QPI		METRIC ACHIEVEMENT
	Goal	Actual			Goal	Actual	
DY3	550	1,705	Achieved	No			
DY4	550	325	Not Achieved	No			
DY5	1,705	5	Not Achieved	No			



The QPI Progress Summary table (see above) displays the QPI Goals and QPI Actuals side-by-side by demonstration year and indicates whether QPI goals (both total QPI and MLIU QPI, if applicable) were achieved according to template calculations. **Do NOT submit a metric for payment if the Total QPI and/or the MLIU QPI (if applicable) show Not Achieved**.

If a provider's QPI Actual is less than what the provider achieved for their DY3 or DY4 QPI, the provider should enter an explanation for the decrease in their progress update in the online reporting system.

De-Identifying Personally Identifiable Information

Providers are required by the HHSC Medicaid Provider Agreement, as well as state and federal law, to adequately safeguard individually identifiable Patient Information. Providers are required to submit only de-identified information as evidence of meeting a metric. (De-Identified Information means health information, as defined in the HIPAA privacy regulations as not Protected Health Information, regarding which there is no reasonable basis to believe that the information can be used to identify an Individual. See the "WARNING NOTICE Regarding Submission of Supporting Documentation" in the October DY4 Reporting Companion Document for more information on Protected and De-Identified Health Information.)

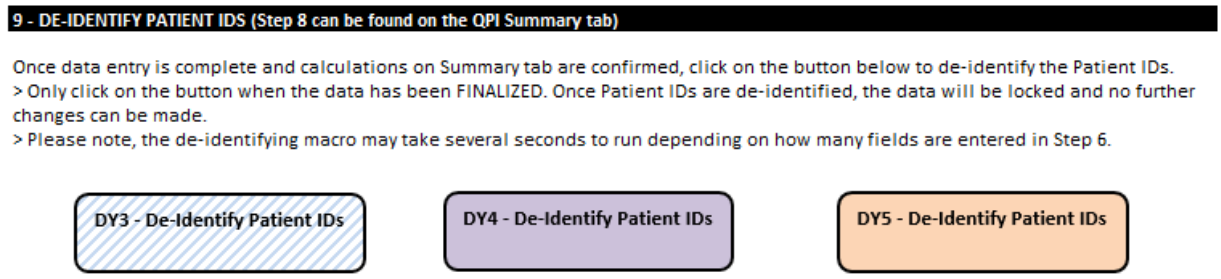
The QPI Reporting Template includes a step to help de-identify the patient IDs that were pasted into the template. During this process, a macro will apply a scrambling methodology to the Patient IDs entered by the provider. As was stated under Step 6, providers are ultimately responsible for ensuring that the data submitted to HHSC

excludes confidential or personally identifiable information. Providers should review the data in the template prior to submission to ensure it conforms to HIPAA and other privacy regulations.

Step 9:

Providers should be sure they have completed steps 1 - 8 and require no changes before completing Step 9.

Once the provider verifies that all data has been correctly entered and they are ready to submit the information entered for this metric, they will return to the Metric QPI Data Entry tab and run the macro to de-identify the QPI data (patient IDs). Providers who are reporting in two different DYs will need to complete Step 9 twice – once for each DY. To run the macro, click on the applicable DY's De-Identify Patient IDs button. (See image below.) If a provider has entered a large number of patient IDs, this process may take a little time. Please do not attempt any other actions in the QPI Reporting Template until this step has been completed.



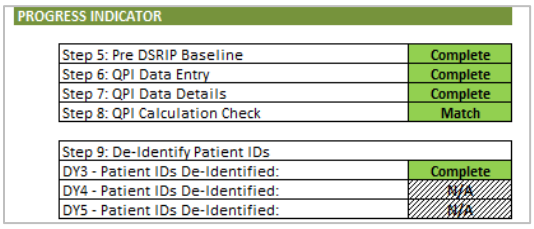
Once de-identifying is complete, the DY# - Patient IDs De-Identified progress indicator will show complete for the applicable DY. Once Step 9 is completed for one DY, the provider should repeat Step 9 for any remaining open DYs.

After Step 9 is run, DY data under Step 6 on the QPI Data Entry tab may be greyed out and locked. This will occur once a provider has indicated they have reported for metric achievement for the DY and they have reported for SAR purposes for the DY. Providers may now save the template (see Naming and Submitting QPI Reporting Template below).

Submission of QPI Reporting Template

Progress Indicators

Before submitting the QPI Reporting Template, please confirm that, in addition to the Progress Indicators on the Project Data Entry tab, Progress Indicators on the QPI Data Entry tab(s) show a green “Complete” for all sections (see image below).



Naming and Submitting QPI Reporting Template

In order to allow HHSC to locate QPI Templates after they are downloaded from the online reporting system more easily, providers are asked to name their QPI Reporting Template as follows: RHPXX_ProjectID_QPI_OctDY5.xlsm (e.g., RHP08_123456789.1.1_QPI_OctDY5.xlsm). Please be sure to follow this naming convention, as it takes a significant amount of staff time to change file names.

Also, be sure to continue to save the file as a macro-enabled file [with an .xlsm (preferred) or .xlm file extension]. Remember, providers will not be able to save the *QPI Reporting Template* until the last step (Step 9: De-Identifying Patient IDs) is completed. The QPI Reporting Template should be uploaded to the online reporting system along with all other applicable supporting documentation as described in the October DY5 Reporting Companion and the DSRIP Online Reporting System Users Guide.

Troubleshooting QPI Template Issues

The section below includes many of the issues providers contacted us about during completion of their QPI Templates along with the tips we provided to get these issues resolved.

"I received a run time error while working on my template".

- If you receive a run-time error 91 upon opening the QPI Reporting Template, please click "End" and continue working through the workbook. All functions should still be available.

I did not serve any clients and do not have any Step 6 data to enter, so my progress indicator is red and I cannot complete Step 9.

- Enter NA in the first cell under Patient ID. Do not enter a date under Encounter Date. This will change Step 6 to complete. It will also allow the template calculation to equal 0, since an encounter date between the eligible dates of service is not present.

"The QPI Template is calculating my QPI incorrectly." or "The Provider and Template Calculations in my QPI Template don't match."

- Confirm you have enabled macros in the QPI Template and have set the template to auto calculate formulas.
- Confirm that dates were correctly pasted into the Encounter Dates column in Step 6. Dates incorrectly entered may be omitted from QPI Template calculations.
    - Confirm the PASTE VALUES option was used when pasting encounter dates (and patient IDs).
    - Check the Encounter Dates column for dates in red text. These dates have some sort of issue that is not allowing them to be counted towards QPI.
    - Confirm that all encounter dates include a month, a day, and a year.
    - If you are including times in your encounter dates, it is possible that the template is not including dates that equal your end date. In order to have those dates included in the template calculation, you may need to include a time in your Step 7 end date. To add a time stamp to the end date, you must click into the formula bar, type " 11:59:00 PM" after the date, and press enter. Please note that there are two spaces preceding the time stamp, and one space between "00" and "PM." The time stamp must be entered in this exact format.
    - Check encounter dates to be sure they do not include spaces before or after the date.
    - Check that the encounter dates you are counting in your provider calculation fall within the date ranges entered in Step 7.

- Confirm that the annualized pre-DSRIP baseline in Step 5 matches the pre-DSRIP baseline you are using to calculate QPI. Providers who enter a full year of pre-DSRIP data based on DY2 (i.e., with a pre-DSRIP baseline start date of 10/1/2011 and end date of 9/30/2012) will see that their pre-DSRIP baseline is actually lower than the annual service volume they entered when it annualized. This difference is due to 2012 being a leap year and including an extra day. This difference should not alarm providers, as it will actually result in a higher QPI achieved than the provider would have seen if the non-annualized pre-DSRIP baseline had been used.

    - If you accept the annualized pre-DSRIP baseline, please be sure the QPI Actual on the Project Data Entry tab is updated to reflect this lower pre-DSRIP baseline.
    - If you prefer your pre-DSRIP baseline not be annualized due to the leap year, change your pre-DSRIP baseline (Step 5) start date to one day later and note this was done in the Step 5 description box.

- Confirm your understanding of pre-DSRIP baseline and QPI calculation is correct.

    - Some providers continue to be confused about pre-DSRIP baseline. Providers should re-review the Determining Pre-DSRIP Baseline section of this document to confirm they understand the difference between pre-DSRIP and DSRIP baseline and that they correctly entered their pre-DSRIP baseline in Step 5.
    - Some providers continue to be confused about how QPI is calculated and how pre-DSRIP baseline affects the calculation. Providers with a project that expands an existing service or program should re-review the QPI Calculation and the How the QPI Template Calculates QPI and Why sections of this document. They should confirm that they entered all applicable individuals served/ encounters provided in Step 6 and note that the annualized pre-DSRIP baseline number of individuals or encounters entered in Step 5 is being subtracted from the total number of unique individuals or encounters (depending on the QPI grouping) entered in Step 6.

- Confirm that your calculation aligns with the QPI grouping listed in your template. For QPI metrics that are individuals-based, providers should confirm that they are not counting an individual (i.e., a Patient ID) more than once in the DY in their calculations. The QPI Template will only count a unique patient ID once towards an individuals-based QPI count.

"The QPI metric information (e.g., numeric goal, baseline/goal, etc.) included in the QPI Reporting Template is incorrect."

- If you believe your QPI goal, baseline/goal statement, MLIU percentage goal, etc. are incorrect, please take the following steps:
- Compare what's in the QPI template with what is listed in the Online Reporting system. If there is a mismatch between the template and the reporting system, email HHSC as soon as possible, so we can identify any mistakes and get them corrected. If the template matches the online system, please continue with the next step.
- Check the Change Request tracker and workbook for any feedback that might be included regarding your QPI metric. It is possible that a Change Request was not approved or that a metric was revised somehow during that process. If the QPI template does not match information included in the Change Request tracker regarding your metric and/or does not match the Change Request workbook (for DY4 or DY5 QPI metrics only), please contact the Waiver mailbox. If there is no discrepancy here, please continue with the next step.
- Check the Phase 4 workbook to determine if a change was requested and made during Phase 4 or if a change you requested and thought was made was not approved during Phase 4. If there is a discrepancy between the

QPI template and what was agreed upon during Phase 4, please contact the Waiver mailbox. If there is no discrepancy, please continue with the next step.

- For 4-year projects, check your final Phase 2 (QPI) submission to confirm that the information in the QPI Template matches what was agreed upon during Phase 2. If there is a discrepancy, please contact the Waiver mailbox.